

RICK SNYDER GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES LANSING

NICK LYON

Early Hearing Detection and Intervention Program

TO: Early On Coordinator	DATE:
County: County Early On®Michigan Coordinator	PAGES (including this one):
FAX NO. (734) 242-5807	
FROM: Michelle Garcia Follow-up Consultant	PHONE NO: 517/335-8878
AGENCY: Early Hearing Detection and Intervention Program Michigan Department of Health and Human Services	FAX NO. 517/335-8036

Attached is a referral for a child identified with hearing loss. If this child is unknown to you, please contact the diagnostic center and discuss how collaboration between sites can be improved.

Please ensure that the Early On Service Provider assigned to this case completes and returns the attached Intervention Status Follow-Up Form. **At minimum ensure the signed IFSP date is documented.** This form allows us to verify that early intervention services were offered to the family and helps us improve statewide services for infants and children identified with hearing loss.

If authorization to share with EHDI is not attached, please be sure to get consent to share with EHDI on the EHDI Intervention Status Follow-Up Form (attached), or the Early On Authorization to Share Form.

If you have any questions, please do not hesitate to contact me. Thank you for serving Michigan's Children!

Michelle Garcia, Follow-up Consultant Michigan Early Hearing Detection and Intervention Program (517) 335-8878 Phone, (517) 335-8036 Fax

IMPORTANT NOTICE: Confidentiality Notice: The documents contain information from the Michigan Department of Health and Human Services, which is confidential in nature. The information is for the sole use of the intended recipient(s) named on the coversheet. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying, or the taking of any action in regard to the contents of this information is strictly prohibited. If you have received this fax in error, please telephone us immediately so that we can correct the error and arrange for destruction or return of the faxed document.

Authority: Title XIX of the Social Security Act Completion: Voluntary

Penalty: None

The Depart. of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.



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Early Hearing Detection and Intervention Program

Hagring Intervention Status Form: Child with Hagring Loss Identified

Hearing Intervention Status	rorm: C	Jiiia w	in Hearing Loss ideni	imea		
FAX:			Date:			
To: Early On®Michigan Coordinator						
From: Michelle Garcia, EHDI, Follow-Up Consultant, 517/335-8878						
RE:	DOB:		Kit Number:			
DX Hearing Loss:						
Early On Services:						
Already enrolled in EO system?	Yes	No	IFSP Signed Date:			
Parents refused EO services?	Yes	No				
Other disabilities identified?	Yes	No				
Educational Intervention:						
Coordinating Interventionist's name:			Phone:			
School System:						
A person with HI experience on the IFSP?	Yes	No				
Audiological Intervention:						
Coordinating Audiologist's name:			Phone:			
Audiologic monitoring every 3 months?	Yes	No				
Amplification option chosen?	Yes	No	Fit date:			
Amplification monitored every 3 months?	Yes	No				
Cochlear Implant option chosen?	Yes	No				
Communication Skills Intervention:						
Parent-Infant Program?	Yes	No				
Family Support:						
Resource guide distributed? (Form # MDHHS-0376)	Yes	No	Date: (for	r copies 517/33	5-8955)	
Community Mental Health Services?	Yes	No				
Children's Special Health Care Services?	Yes	No				
Family-to-Family Support Referral?	Yes	No	(EHDI Parent Cor	nsultant 517/24	1-7066)	
Medical Intervention:						
Coordinating Physician:			Phone:			
Risk indicator for hearing loss identified?	Yes	No	Risk Indicator:			
Physician involved in IFSP?	Yes	No				
Otolaryngology evaluation?	Yes	No	Referral in process?	Yes	No	
Ophthalmology evaluation?	Yes	No	Referral in process?	Yes	No	
Genetic evaluation? Clinic?	Yes	No	(for MDHHS Genetics 517/335-8887)			
I hereby give my permission to the Early On staff to release this intervention information to the MDHHS/EHDI. I understand that						
MDHHS/EHDI uses this information to help ensure that n	ny child red	ceives and	propriate services MDHHS/EH	DI uses unidenti	fied	

MDHHS/EHDI uses this information to help ensure that my child receives appropriate services. MDHHS/EHDI uses unidentified combined intervention information to help improve statewide services.

Parent signature:	Date:
FAX BACK TO 517/335-8036 by:	Date Faxed Back: